

10/27/2014

Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011 | The Henry J. Kaiser Family Foundation

TABLE 4: TOTAL NUMBER OF RESIDENTS AND FACILITY OCCUPANCY RATES FOR CERTIFIED NURSING FACILITIES

STATE	NUMBER OF RESIDENTS						FACILITY OCCUPANCY					
	2004	2007	2008	2009	2010	2011	2004	2007	2008	2009	2010	2011
AL	341	419	403	429	444	471	84.5%	81.0%	81.4%	87.1%	91.8%	91.3%
AK	17,677	15,347	21,492	23,202	22,930	22,229	87.3%	85.3%	87.1%	89.6%	90.0%	85.4%
AR	17,700	17,879	17,889	17,477	18,537	18,853	71.5%	71.2%	72.9%	72.8%	73.3%	72.8%
AZ	12,077	11,276	11,877	11,748	11,623	11,307	77.8%	75.1%	72.5%	76.7%	72.3%	70.4%
CA	82,180	87,530	101,797	100,578	101,834	100,866	85.3%	85.6%	84.2%	84.8%	85.0%	84.2%
CO	15,485	16,516	15,911	16,158	16,138	15,224	83.1%	81.1%	82.6%	82.0%	80.8%	80.5%
CT	26,566	25,991	25,326	26,179	25,370	25,492	72.2%	71.4%	72.0%	72.3%	72.7%	71.7%
DE	2,756	2,666	2,839	2,519	2,245	2,169	72.5%	71.0%	74.9%	72.6%	72.4%	71.4%
FL	1,677	1,900	4,111	4,145	5,597	4,396	82.2%	86.0%	84.9%	84.8%	86.3%	86.1%
GA	71,414	69,978	71,681	71,373	72,730	72,373	89.3%	89.7%	88.7%	87.8%	87.6%	87.6%
HI	10,101	11,087	15,815	16,516	17,788	17,584	89.7%	87.6%	88.6%	87.6%	86.4%	85.2%
IL	1,845	1,479	1,799	1,871	2,819	3,012	91.4%	95.4%	95.1%	91.0%	91.7%	91.4%
IN	26,009	24,868	25,723	25,676	25,200	25,165	79.8%	81.6%	81.6%	80.2%	79.8%	79.2%
ID	4,297	4,132	4,537	4,627	4,258	4,276	78.8%	74.8%	75.6%	71.8%	72.8%	69.8%
IA	23,262	24,061	24,337	25,218	24,271	24,564	75.8%	79.8%	79.1%	78.0%	78.3%	78.3%
KS	10,472	10,015	10,666	10,770	10,230	10,046	72.6%	81.8%	81.2%	80.8%	79.6%	78.3%
KY	19,454	16,518	19,198	18,736	18,491	18,491	77.1%	83.3%	84.5%	81.2%	82.5%	82.7%
LA	21,668	22,954	21,720	22,950	21,170	22,680	88.3%	90.1%	90.6%	90.0%	90.1%	89.6%
MA	25,090	25,787	25,781	25,617	25,470	25,572	75.0%	74.6%	74.0%	71.4%	71.7%	72.5%
MD	46,513	42,414	40,971	43,201	42,848	42,160	88.1%	90.0%	90.1%	89.1%	88.4%	88.3%
ME	26,712	23,092	26,823	26,951	25,647	26,632	88.3%	87.3%	86.2%	87.3%	86.8%	87.6%
MI	6,345	6,349	6,351	6,164	6,299	6,265	91.1%	91.4%	91.1%	89.9%	91.0%	91.0%
MN	29,058	29,053	29,071	29,251	29,917	29,683	86.2%	88.4%	86.0%	87.2%	84.6%	85.0%
MO	30,867	30,264	30,196	29,871	29,871	29,150	92.8%	92.4%	92.4%	91.3%	90.5%	90.6%
MS	20,943	16,696	17,354	17,084	17,641	17,470	89.6%	74.2%	74.1%	72.2%	71.9%	71.0%
MT	16,041	16,779	15,547	16,491	16,367	16,342	87.2%	87.8%	89.5%	89.3%	88.4%	88.2%
NE	6,199	6,743	6,178	6,930	6,291	6,279	71.3%	74.2%	71.2%	71.1%	70.4%	69.5%
NH	17,812	17,760	17,081	17,612	17,323	17,092	84.1%	81.2%	82.2%	83.6%	83.6%	86.2%
NJ	5,870	6,775	5,488	5,479	5,689	5,727	91.8%	91.8%	92.1%	90.2%	87.6%	90.1%
NM	13,043	11,966	12,317	12,670	12,609	12,277	81.4%	81.2%	81.9%	79.4%	80.5%	78.3%
NY	6,238	6,973	6,136	6,938	6,720	6,892	83.1%	83.8%	85.8%	87.3%	88.4%	89.7%
NC	44,110	45,459	45,421	45,619	45,784	45,642	87.6%	88.2%	87.3%	89.8%	89.1%	87.9%
ND	5,264	5,276	5,358	5,370	5,561	5,442	87.3%	87.1%	88.1%	81.4%	81.0%	81.6%
OH	6,711	4,712	4,691	4,761	6,240	4,712	80.7%	84.1%	81.8%	82.2%	80.9%	81.4%
OK	110,119	108,110	107,257	107,218	106,042	107,480	92.6%	92.6%	92.2%	92.4%	92.1%	91.8%
OR	22,848	22,733	22,992	22,689	22,180	22,102	86.2%	87.8%	87.2%	85.9%	85.1%	85.1%
PA	19,154	18,673	19,416	19,534	19,561	19,654	64.1%	66.0%	65.8%	66.8%	66.1%	62.1%
RI	7,767	7,957	7,910	7,688	7,587	6,983	64.2%	64.9%	65.1%	62.6%	61.4%	61.4%
SC	29,878	29,417	28,981	28,679	28,618	28,310	95.0%	91.3%	91.0%	90.8%	91.0%	90.4%
SD	8,307	7,934	7,737	7,725	7,882	8,075	92.3%	91.3%	92.7%	91.2%	90.2%	91.2%
TX	15,700	16,187	16,611	16,944	17,111	17,141	82.9%	93.1%	91.8%	91.3%	91.0%	89.5%
UT	6,547	6,151	5,644	6,511	6,544	6,448	98.4%	99.9%	99.5%	91.5%	94.4%	100.0%
VA	11,870	11,026	11,069	11,157	12,060	10,910	87.6%	88.1%	87.5%	86.3%	85.7%	84.9%
VT	6,644	6,678	6,216	6,348	6,127	6,159	73.4%	74.4%	71.5%	71.4%	71.1%	69.8%
WA	5,197	4,218	5,671	5,146	4,811	4,851	71.2%	70.2%	70.4%	64.8%	66.1%	66.1%
WY	27,220	26,972	28,233	28,112	28,439	28,164	88.2%	91.0%	90.6%	89.2%	88.6%	88.3%
WV	2,861	2,881	2,871	2,881	2,899	2,858	91.6%	90.3%	91.3%	89.9%	88.5%	82.6%
WY	18,672	18,624	18,618	18,603	18,695	17,527	85.4%	84.7%	86.6%	83.1%	82.6%	80.6%
DC	31,612	32,371	32,754	30,441	30,194	29,467	88.4%	88.4%	87.6%	85.8%	81.9%	81.1%
PR	8,014	8,014	8,212	8,541	6,770	2,155	90.4%	89.4%	90.1%	88.2%	86.9%	84.1%
NY	2,111	2,354	2,618	2,377	2,415	2,391	79.5%	81.8%	79.1%	79.9%	81.8%	81.6%
US	1,375,661	1,348,210	1,388,187	1,391,127	1,385,211	1,366,290	85.4%	85.2%	84.8%	83.7%	81.7%	81.8%

(<http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8456-table4.png>)

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TABLE 5: PERCENT OF NURSING FACILITY BEDS BY CERTIFICATION CATEGORY IN THE U.S.

State	Long-Term Care						Intermediate Care						Respite Care					
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2000	2001	2002	2003	2004	2005
AL	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%	1.1%
AK	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
AR	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
AS	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
AZ	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
CA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
CO	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
CT	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
DE	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
DC	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
FL	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
GA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
HI	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
IA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
ID	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
IL	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
IN	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
KS	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
KY	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
LA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MD	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
ME	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MI	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MN	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MO	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MS	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
MT	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NE	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NH	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NJ	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NM	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NY	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
NC	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
ND	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
OH	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
OK	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
OR	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
PA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
RI	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
SC	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
SD	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
TN	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
TX	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
UT	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
VA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
VT	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
WA	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
WI	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
WY	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
All	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%

(<http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8456-table-5.png>)

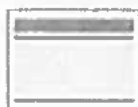
10/27/2014 HIV Screening and Access to Care: Exploring the Impact of Policies on Access to and Provision of HIV Care - HIV Screening and Access to Care - NC

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HIV Screening and Access to Care: Exploring the Impact of Policies on Access to and Provision of HIV Care

The Institute of Medicine (IOM), in response to a request from the White House Office of National AIDS Policy (ONAP), convened a committee in 2009 to plan and conduct a series of three workshops and data gathering activities to evaluate barriers to expanded HIV testing and treatment programs. The committee's first report focused on the extent to which federal and state laws and policies, private health insurance policies, and other factors inhibit or promote expanded HIV testing (IOM, 2010). This second report prepared by the committee examines how federal and state laws and policies and private health insurance policies and practices affect entry into clinical care and the provision of continuous and sustained care for people with HIV. The committee's forthcoming third report will examine the current capacity of the health care system to administer a greater number of HIV tests and to accommodate new HIV diagnoses (see Box 1).



BOX 1

Statement of Task: What is the extent to which federal, state, and private health insurance policies pose a barrier to expanded HIV testing? Issues for the committee to consider include: What are the current federal and state laws, private health coverage (more...)

As part of its charge for this report, the Committee was asked to consider the following specific questions:

- How can federal and state agencies provide more integrated HIV care services?
- What policies promote/inhibit clinical care services among agencies at the federal level, at the state level, or between state and federal agencies?
- What are federal and state agency policies in funding HIV medication adherence programs? What HIV medication adherence programs work?
- Will insurance companies and other payors pay for the treatment of an HIV-infected person who tests positive for HIV, but whose CD4+ T cell count and/or viral load does not fall within the "official guidelines" of starting antiretroviral therapies?
- What can be done to promote access to HIV treatment for HIV-positive individuals with CD4+ T cell counts greater than "official guidelines"?

The 15-member Committee on HIV Screening and Access to Care is composed of experts in the areas of HIV testing and care policy, HIV/AIDS ethics, epidemiology and biostatistics, HIV/AIDS clinical care, HIV/AIDS care services research, HIV care financing, state HIV/AIDS service programming and implementation, and the behavioral sciences (see Appendix A). The committee held its second public workshop, to explore the second part of its study charge, June 21-22, 2010, in Washington, DC. Invited experts discussed barriers and facilitators to HIV/AIDS care during the

following five workshop sessions: (1) overview of clinical care and social service needs of persons with HIV/AIDS; (2) entry into and sustained HIV/AIDS care: the role of federal and state and private health insurance policies; (3) payment for treatment of earlier stage HIV infection; (4) the role of federal and state agencies in supporting integrated HIV care services; and (5) the impact of housing, mental health, and immigration policies on HIV/AIDS care access and retention (see agenda and biographical sketches of invited experts in Appendixes B and C, respectively).

Report Organization

This report is structured in response to the committee's charge and includes a review of the evidence, where available, from policy documents and the research literature on federal, state, and private health insurance policies as potential barriers or facilitators to improved access to HIV/AIDS care. The committee addresses the question of how federal and state agencies can provide more integrated HIV care services (question 2a) following what it felt was the broader question about policies that promote or inhibit clinical care services among agencies at the federal level, state level, or between state and federal agencies (question 2b).

The committee has attempted to provide evidence supporting the assertions made by workshop speakers, but in some instances there is no research addressing these issues. Testimony provided by workshop speakers should be interpreted as opinion by knowledgeable individuals, unless supported by relevant studies.

BACKGROUND

HIV infection has been transformed from an unvaryingly fatal disease into a chronic disease. In high-income countries, survival for persons with HIV has improved in part due to improvements in therapy. For instance, the average survival time after HIV diagnosis based on surveillance data from 25 U.S. states increased from 10.5 years to 22.5 years from 1996 to 2005 (Harrison et al., 2010).¹ Among HIV-positive persons on antiretroviral therapy (ART) in high-income countries, there have been notable declines in mortality rates and potential years of life lost between 1996-1999 and 2003-2005 (see Table 1) (Antiretroviral Therapy Cohort Collaboration, 2008).

Health Indicator	1996-1999	2003-2005
Mortality rate	~1.5	~0.5
Potential years of life lost	~15	~5

TABLE 1

Health Indicators for Overall (20 years or older) Population by Period of Follow-Up

In many settings, the success of antiretroviral therapy in significantly decreasing morbidity and mortality has been possible because of the provision of a comprehensive set of services to meet the particular needs of persons with HIV disease. The care of HIV-infected patients is complex, and a subgroup of this population disproportionately face tremendous psychosocial problems, substance abuse, comorbid medical conditions, and poverty. Merrill Singer, University of Connecticut, defined a construct that he referred to as syndemics or "the concentration and deleterious interaction of two or more diseases or other health conditions in a population especially as a consequence of social conditions that promote disease clustering." Singer emphasized the need to consider HIV/AIDS in the context of other diseases, mental health issues, social structures and environments, housing, and immigration status, especially for the disadvantaged and marginalized populations disproportionately affected by HIV/AIDS. A comprehensive, multidisciplinary approach is needed to HIV/AIDS services due to the complexity of issues implicated in the health of individuals with HIV/AIDS. Despite the improvements in health for people with HIV who are

in care and on treatment, many people with HIV in the United States enter medical care with advanced disease, have inconsistent adherence, or discontinue therapy prematurely (Lewina et al., 2010). Singer noted the importance of using a syndemics approach to find hidden populations of people with health and social burdens implicated in increased vulnerability for HIV, to help facilitate linkage to and retention in care, and to help reduce health disparities.

There is a lack of reliable, recent estimates of how many individuals who have been diagnosed with HIV/AIDS are receiving care (e.g., have a medical provider, are on antiretroviral therapy, or are receiving psychosocial and support services). One recent study that involved meta-analyses of 28 studies involving 51,323 individuals looked at entry into care and retention in care (having multiple HIV medical visits) among individuals in the United States who were diagnosed with HIV. According to the study, 69 percent of those diagnosed with HIV entered HIV medical care averaged across the time intervals in the studies. Seventy-two percent had entered care within 4 months of diagnosis. With regard to retention in care, 59 percent had multiple HIV medical care visits during intervals from 6 months to 5 years (Marks et al., 2010). Another study found that, in 2003, only 55 percent of HIV-infected persons age 15 to 49 in the United States who were eligible to receive ART were in fact receiving ART (Teahale et al., 2005).

In addition to assessing how many infected individuals do not enter care, there is a need to consider the various points along the care continuum where individuals may fall out of care and the potential barriers and facilitators to care linkage and retention. If the goals of expanded HIV testing are to be met, it is important to ensure the availability of, and access to, care and treatment, as well as the continuity of care for those already linked in.

The focus of this report is policy-related barriers to entry into and sustained clinical care for individuals with HIV. A 2005 IOM report identified many policy-related barriers to access to the standard of care for HIV in the United States (IOM, 2005) (Box 2). The IOM committee faulted the public response to HIV and described a patchwork of public programs offering fragmented care and health care providers inadequately reimbursed for their services. Most of the barriers to care identified in the 2005 IOM report are still present today.



BOX 2

Barriers to HIV Care in 2005 Identified by the IOM's Committee on the Public Financing and Delivery of HIV Care. Current public financing strategies for HIV care have provided care to and extended the lives of many low-income individuals. However, (more...)

POLICIES THAT PROMOTE OR INHIBIT CLINICAL CARE SERVICES AMONG AGENCIES AT THE FEDERAL LEVEL, STATE LEVEL, OR BETWEEN FEDERAL AND STATE AGENCIES

Jennifer Kates, Kaiser Family Foundation, noted that the health care financing and delivery system in the United States has gaps in access to care that vary by state. Problems in accessing care can be acute for the general population, but they are particularly onerous for individuals with HIV/AIDS who, as a group, are more likely to be poor and disadvantaged. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (ACA) that extensively changes the way in which health care is financed and provided in the United States (P.L. 111-148). This section of the report provides an overview of federal and state programs and policies that affect access to HIV/AIDS care and how these programs may be affected by the recent health care

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Health Insurance Policies

Having health coverage is critical to gaining access to HIV/AIDS-related care due to the high expense involved in medical management of the disease. Care for people with HIV may be covered through federal programs such as Medicaid, Medicare, the Ryan White program, and the Department of Veterans Affairs (VA), community health centers (CHCs), private health insurance, or through a combination of programs.

There are no recent national estimates of health coverage of individuals with HIV. The HIV Cost and Service Utilization Study (HCSUS), for example, the only nationally representative study of people with HIV/AIDS in care was conducted in 1996.² A recent analysis of data from a convenience sample involving 12 medical sites located in urban cities throughout the United States, showed that the majority of patients were covered under Medicaid (42 percent, including those dually eligible for Medicare) and the Ryan White Program (24 percent) (Table 2).³ These data likely do not represent the national picture of health coverage of individuals with HIV, however, such as those in non-urban areas.

TABLE 2

Estimates of Insurance Coverage Among Patients with HIV Attending Medical Offices Participating in HIVRN, 2010

Medicare, Medicaid, and the Ryan White Program provide the majority of the public funding for HIV/AIDS care (Figure 1). Of the \$13.2 billion in total federal expenditures for HIV/AIDS care in FY 2010, 75 percent represents mandatory spending on entitlement programs (i.e., Medicare, Medicaid, and the Federal Employee Health Benefits program) and 25 percent represents discretionary spending (e.g., Ryan White, VA, and the Substance Abuse and Mental Health Services Administration [SAMHSA]), which is dependent on annual congressional appropriations (KFF, 2010f).



FIGURE 1

Federal funding for HIV/AIDS care by program, FY 2010 (in billions) SOURCE: KFF, 2010f

There are many potential health coverage pathways and associated eligibility criteria for people with HIV/AIDS. Coverage varies by payer as well as several other factors including age, employment status, citizenship, and health status/residence (Table 3).

TABLE 3

Potential Eligibility Criteria for People with HIV/AIDS, by Major Payer/Source

Federal and State Health Insurance Programs⁴

Medicaid Medicaid is the nation's principal safety-net health insurance program and represents the largest expenditure on health coverage for people with HIV/AIDS when federal and state expenditures are combined. The program is a federal-state partnership, with each state and territory

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operating its own Medicaid program under broad, federal guidelines. Medicaid is a guaranteed entitlement to U.S. residents and documented immigrants, and federal funding is provided to match state funds for those eligible for coverage. In 2009, 47.8 million people were covered by Medicaid (DeNavas-Walt et al., 2010). An estimated 200,000-240,000 individuals with HIV/AIDS receive care through the Medicaid program (KFF, 2009a). Federal spending on Medicaid in FY 2010 is estimated at \$275.4 billion,⁵ with an estimated \$4.7 billion going to HIV care (KFF, 2009b), and additional state spending on HIV care is estimated at close to \$4 billion (CMS, personal communication, September 2010).

Minimum eligibility requirements for Medicaid are set by federal law. To be eligible for Medicaid, an individual must be both low income and "categorically" eligible. There are several pathways to Medicaid coverage (Table 4). The large majority of persons with HIV on Medicaid qualify on the basis of being both low income and disabled, as determined by their eligibility for Supplemental Security Income (SSI) benefits. Because states have discretion in designing and administering Medicaid programs, there is considerable variation by state in eligibility, benefits, and other aspects of program. In addition to the mandatory groups that all states must cover to receive federal matching funds, there are optional eligibility groups that states can choose to cover and receive federal matching funds. For instance states have the option to offer eligibility for individuals with income above the threshold for the state (Table 4) (KFF, 2009a).

TABLE 4
Medicaid Eligibility Pathways for People Living with HIV/AIDS.

Income eligibility requirements for Medicaid vary greatly by state, and are often very restrictive. For instance, in 34 states, low-income parents must have incomes less than the federal poverty level (FPL) to be Medicaid eligible; in 17 states, incomes must be less than 50 percent of the FPL (KFF, 2009c).⁶ Programs and benefits also vary. For example, only 33 states and the District of Columbia have a program for individuals who are medically needy to serve people who have incomes that are too high to qualify for Medicaid but who are otherwise eligible (this is an optional program under Medicaid) (KFF, 2009b), and 19 states have prescription drug limits (e.g. monthly or annual limits on the number of prescriptions) within their Medicaid programs (KFF, 2008).

Heather Hauck, Maryland Department of Health and Mental Hygiene, discussed how some but not all states have Medicaid expansion programs allowing coverage for non-disabled individuals. In addition, there is limited coverage for nonmedical services, such as case management and housing, under Medicaid. Medicaid data system limitations may restrict the ability of administrators to assess who is in care and the appropriateness and outcomes associated with that care.

Other barriers to access to Medicaid coverage include the onerous application process in some states; a restrictive definition of disability that excludes persons with HIV who do not have an AIDS diagnosis and who are capable of engaging in "substantial gainful activity" (although this will be alleviated with changes to categorical eligibility criteria that will no longer require an AIDS diagnosis/disability under the ACA), and limited beneficiary autonomy in choosing a care provider (Rawlings and Hopson, 2009).

Andrea Weddle, HIV Medicine Association (HIVMA), indicated that Medicaid reimbursement rates are a barrier to HIV clinic sustainability. According to recent estimates, Medicaid rates for primary care average 66 percent of Medicare rates and range from 47 percent (California) to 140

percent (Alaska) (Zinkman et al., 2009).⁷ In general, the rates increased by 15.1 percent from 2003 to 2008; however, the consumer price index increased by 20.3 percent during this period. Weddle mentioned that states that have greater coverage of benefits tend to have lower provider payment rates. Low provider reimbursement rates have been shown to hinder access to care for Medicaid beneficiaries in particular (IOM, 2005).

Medicaid coverage of HIV testing is discussed in the committee's first report (IOM, 2010). States must cover all medically indicated/physician ordered HIV tests, but states have the option to cover routine HIV screening.

Medicare/Medicaid is the federal health insurance program for individuals who are age 65 and older and individuals under age 65 who are disabled. Medicare provides coverage to 47 million Americans (KFF, 2010c), including an estimated 100,000 people with HIV/AIDS (KFF, 2009b). Medicare spending in FY 2010 is estimated at \$515 billion with \$5.1 billion in expenditures for HIV/AIDS (KFF, 2009c). The program has four parts:

1. Part A covers hospital stays, skilled nursing care, facility stays, home health care, and hospice care (automatically provided if eligible);
2. Part B covers physician payments, outpatient services, preventive services, and home health care (those eligible for Part A may enroll);
3. Part C covers Medicare Advantage (voluntary enrollment in private health plans, such as a health maintenance organization); and
4. Part D covers prescription drugs; low income subsidies (voluntary enrollment).

Most individuals with HIV who qualify for Medicare do so because they are disabled (see Table 5 for Medicare eligibility criteria). Medicare beneficiaries may choose to purchase coverage from a selection of competing private plans to cover prescription drugs under Medicare Part D. The cost sharing under Medicare Part D can be problematic for individuals with HIV who qualify on the basis of disability and are receiving Social Security Disability Insurance (SSDI) assistance. Cost-sharing may put pressure on AIDS Drug Assistance Programs (ADAPs), state-run programs funded through Ryan White that provide access to medications for low-income and under or uninsured individuals with HIV who cannot afford out-of-pocket expenses for prescription drugs under Medicare Part D (Rawlings and Hopson, 2009).

TABLE 5

Medicare Eligibility Pathways for People Living with HIV/AIDS

In addition to the limitations on drug coverage, individuals under age 65 must wait 24 months following their disability determination and the initiation of receipt of SSDI before Medicare coverage begins. Also, Medicare benefits are based on income history, which may not reflect current need (Rawlings and Hopson, 2009). Furthermore, many HIV patients do not have sufficient work history, nor have they accumulated sufficient work credits to qualify for needed benefits. On the other hand, provider reimbursement tends to be higher under Medicare than Medicaid (IOM, 2005), resulting in more providers being willing to provide care for patients eligible for Medicare or dually eligible patients, than for patients who only have Medicaid. Coverage of HIV testing through Medicare is discussed in the committee's first report (IOM, 2010). A new policy for

annual voluntary HIV screening for those at increased risk for HIV, as well as voluntary screening for pregnant women during the third trimester of pregnancy and at labor, was issued in December 2009. Persons who request an HIV test despite reporting no individual risk factors could also be tested under the policy, since this group is likely to include individuals not willing to disclose high-risk behaviors.⁸

The Ryan White Program The Ryan White Program is the only federal grant program designed specifically for people with HIV/AIDS. The program is estimated to support services for approximately 530,000 HIV-infected people each year (GAO, 2009b). Federal spending on Ryan White is estimated at \$2.3 billion in FY 2010 (KFF, 2009c). The program has several parts:

1. Part A provides funding to cities (Eligible Metropolitan Areas [EMAs] and Transitional Grant Areas [TGAs]),
2. Part B provides funding to states, including an ADAP capmark,
3. Part C provides funding to public/private organizations for the provision of health services;
4. Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS; and 4. Part F provides funds for several programs such as Special Projects of National Significance (SPNS), AIDS Education & Training Centers (AETCs), Dental programs, and the Minority AIDS Initiative (MAI).

Ryan White is considered the payor of last resort for individuals with HIV/AIDS. Most clients are low income; more than 70 percent have annual household incomes at or below the poverty level. Most clients are uninsured or underinsured and are people of color (KFF, 2009d). Ryan White is a discretionary program dependent on annual federal, and in some cases state and local, appropriations. Funding is provided, based on formulas, to Part A, B, C, and D grantees, with most of the funding going to states and cities. The program often serves as a wrap-around program to pay for medications and services (e.g., case management, transportation) that are not covered by other funding sources. As such, it is considered a lifeline in terms of providing needed services for people with HIV/AIDS. Ryan White services are tailored to the needs of local communities, and therefore there is considerable variation in services that are available across jurisdictions (Rawlings and Hopson, 2009). A constant amidst the variation is that Ryan White programs are limited to HIV-related outpatient services. Inpatient hospital stays and emergency department visits are not covered. Also, there is only a limited panel of covered specialist providers, and coverage for their services extends only to HIV-related issues. In addition to lack of coverage for inpatient or emergent services, one consequence of these limitations is the need for primary care providers to serve also as default cardiologists, nephrologists, hepatologists, and the like, for their Ryan White funded patients.

Hauck noted that additional resources for Ryan White Part B (ADAPs) and Part D (family centered care) are needed to expand clinical services. The restrictions on uses of Ryan White, funding for core medical services versus support services⁹ reduces local flexibility to address client needs. In addition, Hauck stated that federal guidance is lacking on criteria for states to receive supplemental (Part B) Ryan White funding.

Several workshop participants expressed concern about the unmet need for ART medications through the Ryan White ADAP program. As of December 9, 2010, there were 4,543 individuals on ADAP waiting lists in 9 states. An additional 18 states have implemented cost-containment measures (e.g., reduced formularies, lowered financial eligibility, capped enrollment, and

implementation of cost sharing) (NASTAD, 2010). Hauck described the problem of state ADAP formularies that are missing critical classes of drugs for mental health, cardiovascular, and gastrointestinal conditions and the various distribution methods for ADAP medications (e.g., direct order, clinic pick up, ADAP pharmacy only, any pharmacy), some of which pose barriers to clients.

Ryan White funds are limited due to the discretionary nature of the program and often are not sufficient to support the care needs of HIV-infected individuals. In some areas (e.g., suburban, rural) there may be very few or no resources available to people with HIV through the Ryan White program. The complexity and burden of the application process for a Ryan White grant, as well as award conditions that carry administrative requirements related to issues such as quality management, may make it easier for large organizations with more resources to obtain funding (Rawlings and Hopson, 2009).

Weddle highlighted the importance of medical case management in client entry into and retention in care. Medical case management facilitates entry into care for those who are newly diagnosed, especially when co-located or integrated with the HIV medical care team. Case management is a key strategy for coordinating care and assisting patients with meeting a range of medical, psychosocial, and basic living needs. Ryan White currently is the principle source of funding for case management for people with HIV/AIDS, but other sources of support are needed. Estimates indicate that case management for people with HIV is covered by approximately 25 percent of Medicaid programs (HRSA, 2004).

Ryan White funds can be used to support diagnostic and laboratory HIV tests. Testing must be considered "integral to the treatment of HIV infection and related complications."¹⁰

Department of Veterans Affairs The Department of Veterans Affairs, Veterans Health Administration (VHA) is the largest single provider of HIV care in the United States. Federal spending on veteran's medical care in FY 2010 is estimated at \$46.2 billion,¹¹ with an estimated \$0.8 billion going to HIV care (KFF, 2010). To date, nearly 64,000 veterans with HIV have received care in the VHA system. In 2008, more than 21,000 veterans with HIV were served, representing about 1 of every 250 veterans in care. The number of veterans with HIV in care has been relatively stable over the past several years (VA, 2009a).

The VHA provides comprehensive care to a population with complex care needs and prevalent comorbidities including heart disease, diabetes, cancer, depression, hypertension, and hepatitis C. Veterans who meet certain criteria for character at discharge and length of military service can apply for care through the VHA, which is available for free to those who qualify (VA, 2009b). Veterans with service-connected disabilities (disabilities that arose while in service) including HIV are eligible for compensation benefits through the Veterans Benefits Administration and are entitled to VHA care and other benefits such as preference in federal/state employment and job retention rights.

As of August 2009, the VHA's policy on HIV testing includes HIV testing as part of routine medical care. Verbal informed consent for testing is considered sufficient, and pre- and post-test counseling are no longer required.¹²

Federally Qualified Health Centers Federally Qualified Health Centers (FQHCs) are located in or serve a high need community (designated as a Medically Underserved Area (MSA) or population). They provide comprehensive primary health care services as well as supportive services (e.g., education, translation, and transportation that promote access to health care). FQHC

services can be used by anyone, with fees adjusted based on ability to pay. FQHCs include CHCs, Migrant Health Centers, Healthcare for the Homeless, and Public Housing Primary Care Programs.¹³

In 2009, there were 427,797 encounters in CHCs, representing 94,972 patients with HIV/AIDS. CHCs are important testing sites. In 2008, they administered 753,801 HIV tests (HRSA, 2009).

Hauck pointed out that state grantees receiving support from the Health Resources and Services Administration (HRSA) through both the Ryan White program and the FQHC program serve many of the same populations, but there is little coordination at the federal level, aside from that among CHCs that are also Ryan White Part C or Part B funded programs. Not all CHCs provide HIV testing and HIV/AIDS care, and Hauck pointed out that in high HIV and viral hepatitis incidence areas, comprehensive HIV and viral hepatitis testing and care should be provided by CHCs in coordination with state HIV/AIDS programs. This has led some to call for the need for a Policy Information Notice (PIN) from HRSA to provide guidance to these CHCs to expand access to HIV testing and care. In September 2010, HRSA issued such a notice to FQHC program grantees specific to HIV testing in health care settings to provide information on the Centers for Disease Control and Prevention's (CDC) Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings (CDC, 2006) and resources for training and technical assistance to help health centers follow the revised recommendations.¹⁴ A similar notice has not been issued on care for persons with HIV.

High Risk Insurance Pools For some individuals, an insurer of last resort is a state-run, high-risk insurance pool that provides health insurance coverage for individuals who are otherwise uninsurable, for example, because they have a preexisting condition such as HIV. Many states have a high-risk insurance pool (NASCHIP, 2010). However, state high-risk insurance pool policies and practices may pose barriers for those without insurance coverage from other sources. Monthly premiums within such pools can be prohibitively expensive, and although Ryan White funds may be used to pay for premiums, this arrangement can be difficult to make.

Private Health Insurance

Fewer than one in five individuals with HIV (17 percent) are estimated to be covered by private health insurance (HHS, 2010). Coverage for care under private insurance varies depending on state insurance laws. Kates stated that 18 states impose rating limits on insurers providing coverage to individuals. In states without such limits, insurers can vary premiums according to an individual's health status or other attributes. Health insurance sold in the individual market on a "guaranteed issue" basis cannot exclude applicants based on health or risk status. Only 6 states require insurers to offer individuals coverage on a guaranteed issue basis for all products (7 other states have this requirement for selected products).

For individual health insurance policies, there may be a pre-screening application that may exclude coverage for preexisting conditions like HIV disease, although the preexisting condition insurance plan recently implemented under the ACA has already begun to eliminate this exclusion until the broader coverage provisions take effect in January 2014. Caps on benefits, cost sharing for prescription drugs, and co-payments for visits with providers under private health insurance may require that individuals with HIV resort to other programs to supplement payment for their HIV care (IOM, 2005).

Forty-six percent of insured individuals with below average incomes went without needed care (Schoen et al., 2010). Insured individuals may struggle or be unable to cover the costs associated

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with premiums, co-pays, deductibles, and costs of services, such as vision and dental, that are not covered by their plans (Perry et al., 2009). Private insurance policies often have limits on services needed by those with HIV/AIDS (e.g., substance abuse treatment, mental health treatment, case management, specialty care).

Insurance Policies and Access to Expert HIV Care Providers

Evidence indicates that care provided to HIV-infected individuals by medical providers who specialize or have significant experience in HIV care is better than care provided by non-specialists or providers with limited exposure to HIV patients. Although further research is needed, studies conducted in the 1990s and early 2000s demonstrated that patients cared for by physicians, nurses, and other providers who are experienced in the care of individuals with HIV are more likely to have positive treatment outcomes, be prescribed antiretroviral therapy appropriately, and receive more cost effective care (Kitchasa et al., 1996; Landon et al., 2003; Wilson et al., 2005; Hozette et al., 2001).

A requirement that federal payors include HIV medical clinicians in their provider networks would improve access to such clinicians and improve outcomes according to Weidle. This could be accomplished through having contracts with HIV providers or allowing "any willing provider" into the networks.

In general, insurance plans could allow HIV providers to serve as primary care providers. In California, plans can create a standing referral to an HIV provider (State of California Department of Managed Care, 2010). Another way to facilitate care by an HIV specialist is to allow beneficiaries to have direct access to HIV specialists (i.e., eliminate gatekeepers).

Weidle discussed the importance of having access to other specialists as well. She described how insurers ideally would support robust, coordinated, and integrated provider networks to treat the full range of issues affecting people with HIV. Available specialists might include endocrinologists, psychiatrists and other mental health professional, gynecologists, gastroenterologists, cardiologists, nephrologists, hematologists/oncologists, dermatologists, and hepatologists. A number of factors can limit access to these and other specialists: reimbursement, including limited access to specialist care under Ryan White funding; specialist availability; and the provider's level of knowledge and comfort with treating HIV disease.

Health Care Reform and Access to Health Insurance for Persons with HIV/AIDS

Kates discussed how the ACA will expand access to care for millions of Americans who are currently uninsured, including people with HIV/AIDS. According to a recent Kaiser Family Foundation study, Medicaid expansion will significantly increase the number of people covered by the program and markedly reduce the number of uninsured individuals in states across the country, with the federal government picking up the majority of cost (KFF, 2010f). States with large uninsured populations today are expected to see the biggest increases in Medicaid coverage.

Medicaid will be expanded to all individuals under age 65 with incomes up to 133 percent of the FPL as of 2014 (there is a state option to begin enrollment as of April 1, 2010). There will be a uniform minimum Medicaid eligibility threshold across states. The categorical eligibility criteria that have prohibited most low-income adults, including those with HIV/AIDS, without dependent children from enrolling in the program will be eliminated. As is the case under current law, undocumented immigrants still will not be eligible for Medicaid coverage under the ACA (KFF, 2010a). Uninsured individuals with incomes greater than 133 percent of FPL will be able to obtain

coverage through newly created state health insurance exchanges.

The Medicare program provides coverage for the elderly and individuals under the age 65 who are disabled. Under the ACA, there will be an end to the Medicare Part D drug benefit coverage gap (referred to as the "doughnut hole") by 2019. ADAP payments will count toward the true out-of-pocket threshold used to determine eligibility for catastrophic coverage under Part D. Kates highlighted the improvement in coverage of prevention benefits under Medicare. As of 2011, there will be no coinsurance or deductibles charged in traditional Medicare for preventive services that are rated A or B by the U.S. Preventive Services Task Force (USPSTF).¹⁵

Kates mentioned that private health insurance eligibility and coverage will change under health care reform. The ACA requires guaranteed issue and renewability of policies. This means that health insurers will be prohibited from denying coverage for any reason, including health status, and also from charging people more for their policies based on health status and gender. Until these reforms are in place, a temporary (from 2010 to 2014) national high-risk pool has been established to meet the needs of those with preexisting conditions. As of 2010, young adults are able to remain on their parent's health insurance plan up to age 26.

In terms of coverage, Kates described how the ACA will end annual and lifetime limits for those with private insurance coverage. Insurers offering individual or group plans will also have to provide coverage and may not impose any cost sharing requirements for evidence-based preventive services (e.g., those rated A or B by USPSTF).

As part of health care reform, a Prevention and Public Health Fund was established, with an initial appropriation in 2010, to expand and sustain funding for prevention and public health programs. The fund includes support for federal, state, and community initiatives to use evidence-based interventions to address HIV-related health disparities.

Although the ACA will expand access to health insurance and provide new protections for individuals with private coverage, some individuals still will not gain access, such as undocumented immigrants, who will continue to be excluded from Medicaid coverage (KFF, 2010a). There will be a host of implementation challenges, and until the reforms are in place, the coordination of existing programs will be critical. Of concern is the possibility that routine HIV screening will not be covered under the ACA, which runs counter to the recent efforts to expand HIV testing in the United States. The ACA relies on the recommendations of the USPSTF, which do not currently recommend routine HIV screening. Uncertain also is the role of the Ryan White program following implementation of health care reform.

Under the ACA, there are opportunities to expand access to providers experienced in the care of individuals with HIV. Weddle described how health plans operating in state-based exchanges beginning in 2014 will be required to contract with essential community providers, such as those eligible for reduced drug pricing under section 340b of the Public Health Service Act,¹⁶ including FQHCs, FQHC look-alikes, and HRSA grantees, such as Ryan White programs.¹⁷ It is not yet known whether plans will proactively contract with Ryan White providers and whether the Ryan White programs will be prepared to negotiate contracts and then have the capacity to bill and respond to administrative requirements of private plans (e.g., stricter utilization management requirements). Weddle expressed the concerns of HIVMA over the way in which the health care reform increases Medicaid payments to primary care physicians for 2013 and 2014, but leaves out those HIV physicians who are infectious disease specialists but also provide primary care to their patients.¹⁸

Housing Policies

David Holtgrave, Johns Hopkins Bloomberg School of Public Health, described a large body of evidence on the relationship between homelessness and HIV infection. Studies conducted among persons who were homeless or unstably housed in New York City, Philadelphia, and San Francisco, for instance, have shown HIV seroprevalence rates several times higher than that seen in the general population (Culhane et al., 2001; Kerker et al., 2005; Robinson et al., 2004). Housing status is also associated with greater prevalence of HIV-related risk behaviors such as injection drug use and unsafe sex among HIV-infected individuals (Aidala et al., 2005, 2006; Kikder et al., 2007). For example, Table 6 shows the increased odds of recent needle use among HIV-infected individuals in New York City and in a national sample who were either stably or unstably housed or were homeless.

TABLE 6

Odds of Recent Needle Use Among Persons Living with HIV.

Stably housed individuals with HIV also may be better able to attend to their health than those who are homeless or unstably housed. A systematic review of studies found a significant positive association between stable housing and improved health care and social service use and adherence to antiretroviral medications. Stable housing also correlated with significant benefits in terms of improved health status and a reduction in HIV risk behaviors (Lever et al., 2007). Stable housing appears to improve the survival of people living with HIV/AIDS. Short-term mortality was associated (adjusted hazard ratio 2.92, CI 1.32, 6.44) with recent homelessness, according to one longitudinal study conducted from 1996 to 2005 among 595 individuals living with HIV and alcohol challenges (Walley et al., 2008).

The Housing Opportunity for People with AIDS (HOPWA) program in the Department of Housing and Urban Development provides states and localities with funding to support housing assistance and related services for people living with HIV/AIDS (HUD, 2010b). Ninety percent of HOPWA funding is distributed through a program that uses a statutory formula that relies on AIDS statistics (cumulative AIDS cases and area incidence) from CDC, and 10 percent of HOPWA funds are awarded as grants under a competitive selection of projects proposed by state, city, and local governments or by nonprofit organizations (HUD, 2010b). Holtgrave discussed increased appropriations in 2010 from 2008 levels (\$335 million vs. \$300 million) for HOPWA (HUD, 2010a), and the proposed funding for 2011 is \$340 million (White House, 2010). HOPWA projects that provide permanent supportive housing exceeded the goal that 85 percent of those receiving housing assistance would achieve housing stability in FY 2009 (HUD, 2010b).¹⁹ Yet it is estimated that more than 125,000 households have an unmet need for AIDS housing services (NAHC, 2010). Holtgrave asserted that expanded access to HUD and other housing supports for people living with HIV are among the actions needed to meet the National HIV/AIDS Strategy (NHAS) objective to increase access to care and improve health outcomes for people living with HIV (ONAP, 2010).

Holtgrave mentioned the value of the National AIDS Housing Coalition as a source of data on the effectiveness of housing programs in addressing HIV/AIDS. He testified that the evidence indicates that there are many negative consequences of homelessness, including high medical care costs. People who are homeless have many barriers to health care generally, but use acute care services (e.g., emergency rooms) at high rates (Larimer et al., 2009). "Housing First" policies,

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where the housing needs of individuals are met before attempts are made to address other service needs, such as substance abuse treatment and mental health care, may help to offset costs of care for homeless individuals (Gibner et al., 2009; Larmer et al., 2009; Sadowski et al., 2009).

Despite the persistent correlation between housing status and better health care access and health outcomes, there have been few randomized clinical trials to study whether housing is causally linked to improvements in health and health outcomes (Kiddler et al., 2007). Holgrave reviewed the results of a recent randomized clinical trial, the Chicago Housing for Health Partnership (CHHP) study, that followed 407 homeless individuals who were chronically ill with HIV/AIDS or other conditions for 18 months following discharge from the hospital. The immediate provision of supportive housing following hospital discharge (in contrast to usual care, that is, a piecemeal system of emergency shelters, family, and recovery programs) resulted in significant cost savings (Suckowski et al., 2009). For every 100 persons housed, there were 49 fewer hospitalizations, 270 fewer hospital days, and 116 fewer emergency department visits. Reductions in avoidable health care utilization translated into cost savings for the housed participants, even after taking into account the cost of the supportive housing.

A sub-study of the CHHP involving 94 participants with HIV examined the impact of supportive housing on HIV disease progression. Compared with 34 percent of participants with HIV who were randomized to usual care (discharge planning usually provided to homeless individuals during a hospital stay), 55 percent of participants who received permanent housing with intense case management were alive and had "intact immunity" ($CD4 > 200$ and viral load $< 100,000$) after one year. In addition, the participants randomized to housing and case management were much more likely to have an undetectable viral load (36 percent) compared with those who did not receive these services (19 percent) (Buchanan et al., 2009).

A second randomized trial, the Housing and Health Study, was designed to study the causal effects of providing rental housing to homeless or unstably housed individuals with HIV on physical health, access to medical care, treatment adherence, HIV risk behaviors, and mental health status, using data gathered at baseline and 6, 12, and 18 months (Kiddler et al., 2007). The 630 participants were randomized into two groups: the treatment group received immediate HOPWA rental housing assistance with case management and the control group received "customary housing services with case management." The researchers hypothesized that the "treatment" group, which received immediate rental housing, would demonstrate improvement in all areas, as well as a decrease in HIV risk behaviors, over the control group (Wolitski et al., 2010). Results of the study were complicated by the fact that at 18 months 51 percent of the control group had acquired stable housing, which limited the significance of the results. In an effort to offset this occurrence, data for individuals who had experienced 1 or more nights of homelessness during the study period were compared with those for individuals who had not (Wolitski et al., 2010).

Despite the challenges encountered by the study, the results did show that participants' mental health, especially perceived stress, was positively affected by housing stability. The findings pertaining to the effect of stable housing on physical health were less consistent, although the results of the as-treated analyses showed that individuals who experienced homelessness during the study period were more likely to report one or more emergency department visits in the past 6 months (49 percent vs. 29 percent) and more likely to have a detectable viral load (79 percent vs. 61 percent). There was no difference found between the two groups in terms of HIV risk behaviors (Wolitski et al., 2010). Additional longitudinal studies are needed to assess more definitively the direct and indirect effects of housing stability on the physical health of HIV-infected individuals.

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On May 20, 2009, President Obama signed into law the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act. The act includes a number of measures to improve efforts to reduce homelessness and housing insecurity that are likely to benefit persons with HIV, including a change in HUD's definition of homelessness and chronic homelessness and the establishment of a Rural Housing Stability Program.²⁰

Policies Affecting Immigrants

Undocumented immigrants tend to have poor access to health care, and there are very low rates of testing for HIV/AIDS among immigrants who have not yet acculturated in the United States. Catalina Sol, Chief Programs Officer of La Clinica del Pueblo in Washington, DC, described a number of the barriers to HIV/AIDS care experienced by immigrants. These include:

- a lack of linguistically and culturally appropriate, geographically accessible services, especially mental health services;
- a lack of access to health care;
- culturally mediated health beliefs and attitudes related to knowledge of disease;
- stigma associated with HIV/AIDS and identification as an immigrant;
- conflicts between work status and medical care (many immigrants have more than one job);
- instability/lack of availability of housing (ineligibility for federal housing programs);
- transient residence, often related to fluctuations in the regional job market, and
- a lack of family/support structures.

Sol described how being an undocumented immigrant could diminish access to care for HIV-infected individuals. An increasing focus on legal immigration status has created difficulties for immigrants as they try to interact with police, law enforcement, and state/government entities. In many jurisdictions, undocumented immigrants may not be able to obtain the basic documents (e.g., social security number) necessary to gain employment, obtain a driver's license, open a bank account, rent or purchase a home, or access safety net services. Due to reduced ability for legal recourse, undocumented immigrants are also vulnerable to unfair practices in the workplace, such as underpayment and unsafe working conditions. Many immigrants have a work permit, which is a legal document that helps with identification, but it is temporary, often misunderstood, and confers no benefits.

With some exceptions, "non-qualified" immigrants (i.e., those who do not meet certain eligibility requirements, including those who are undocumented) are prohibited from enrolling in federal public benefit programs, such as Medicaid (except for emergency care), Medicare, Temporary Assistance for Needy Families, and the like (1996 Welfare law, 8 U.S.C. 1613).²¹ Legal immigrants (green card holders) who entered the United States on or after the date the Welfare Law was enacted also generally are not eligible for public benefits until they have been in residence in the United States for 5 years, at which time they can apply for U.S. citizenship or naturalization.²² States have attempted to fill in some of these coverage gaps. About half of states spend their own money to cover at least some immigrants who are ineligible for federal services, and some states or counties provide health coverage to children and/or pregnant women regardless of their immigration status (Broder and Hlazer, 2010).

A 22-year ban on entry into the United States of HIV-infected individuals was lifted in January 2010. Until then, HIV testing was necessary to initiate the application for legal resident status. Sol stated that even without the ban, immigration policy poses multiple barriers to "entry" for low-income immigrants living with HIV. Immigrants must have family-based sponsorship, meet certain employment criteria, or be considered under provisions for asylum or refugee status. Considerations of whether an individual will be a public charge or burden to society are taken into account. In addition to barriers imposed by federal policies, some states have imposed restrictions on access to services for immigrants.

Sol stated that although immigrants with HIV, including those who are undocumented, may be eligible for the Ryan White program, the process for determining eligibility for Ryan White services can be difficult. Eligibility workers are not immigration experts and may be confused about legal access to care. The perception among immigrants that they are not eligible for any services may keep them from seeking care. In some communities there is a growing hostility toward immigrants, which in some cases is reinforced by public policies. Service providers are often confused, fearful, and unsure of how to proceed lawfully. In addition, the geographic movement of many immigrant workers in response to fluctuations in the regional job market may hinder their ability to apply for and receive services.

Legislation focusing on immigration reform might address some of these barriers to care. Service providers could: (1) inform their immigrant clients of the availability of Ryan White services; (2) examine how their organizations or facilities may be discouraging or excluding immigrants unnecessarily; (3) limit questions about immigration status to those necessary to determine eligibility; (4) assuage the fears of immigrant patients; and (5) make alliances with community-based organizations that work with immigration issues and inform them of the special needs of HIV-positive patients.

Undocumented immigrants will continue to be excluded from Medicaid under the ACA, but implementation of this exclusionary policy will be very difficult. The immigration status of individuals within a single family may be very different. A father may have a green card, a mother may be undocumented, and a child born in the United States could have citizenship. Eligibility workers will have a difficult time determining who can gain access to Medicaid and who may purchase health insurance on the exchanges that will be set up. From a human rights and a public health perspective, such exclusionary policies are ill advised. With many immigrants being excluded from coverage under the ACA, the preservation of the Ryan White program is essential because it provides a safety net for individuals with HIV/AIDS regardless of their immigration status.

Correctional System Policies

Given that 1.5 percent of prison inmates are HIV positive or have confirmed AIDS diagnoses (Bureau of Justice Statistics, 2009) and an estimated 15 percent of HIV-infected individuals have contact with the correctional system (Hammett, 2009; Hammett et al., 2002), the provision HIV/AIDS care within the U.S. correctional system is important. Individuals who are incarcerated in jails and prisons are eligible for health care, but HIV/AIDS care is often absent, incomplete, or not coordinated with care that the inmate received prior to admission to the correctional system or that is available upon release. Becky White, University of North Carolina, Chapel Hill, described how sources of health care coverage are discontinued or suspended upon entry into jail or prison. Model programs have shown that individuals can be routinely tested for HIV at entry into the correctional system, cared for during incarceration, and linked to follow-up care post release. To

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succeed in providing comprehensive care, funding is necessary, bureaucratic obstacles must be overcome, and collaboration must be forged between correctional and community-based care systems. It is also crucial to ensure that confidentiality and nondiscrimination policies are in place to protect the well-being of individuals diagnosed or treated in a correctional facility (Seal et al., 2010).

White stated that jails and prisons represent the only sector of society where health care is a constitutionally guaranteed right. However, this right often is not fully exercised because the provision of health care is not the primary goal of the correctional system. Furthermore, even when it is a priority, health care delivery is compromised by inadequate funding and staffing, as well as by policies or practices that may deter inmates from seeking care.

Figure 2 shows the cycle of incarceration and release (and sometimes reincarceration) in relation to jail health care, prison health care, and community health care. Some individuals with short sentences only serve time in jails and then are released, while others with longer sentences may transition through the prison health care system before being released. Release from prison is associated with a significant increase in the risk of death, especially during the first 2 weeks following release, when, in one study, the adjusted risk of death among recently released Washington state inmates was 3.5 times that among other state residents, due in part to renewed substance abuse (Hruswanger et al., 2007). A comprehensive approach to correctional health transitions is important, making maximum use of the links to community-based health care and public health systems.



FIGURE 2

Cycle of incarceration and release and relation to health care.

SOURCE: Adapted from Zaller et al., 2009.

White described several barriers to entry into care that individuals may face as they leave the general community to enter jail. There may be no policy for routine screening for HIV or other infectious diseases, especially in smaller jails with limited resources. Inmates may refuse testing because of concerns about disclosure and a general distrust of the correctional health care system. Jails are characteristically understaffed and must contend with a high turnover of inmates (half of inmates are released within 72 hours). Some jails have no, or very limited, HIV screening/testing policies. These difficulties may not be experienced in very large jails. For example, jails in Los Angeles County, California, and Cook County, Chicago, Illinois, have a medical director available to oversee jail health care. Many states, however, have a jail in almost every county and limited access to medical resources.

Even for individuals identified as HIV positive at entry into jail there are several barriers to receiving HIV care, such as understaffing, poor HIV-related knowledge among staff, and short jail stays. Upon entry into the correctional system, other sources of health care coverage are discontinued or suspended, including Medicare, Medicaid, ADAPs, the VA, and private insurance. The correctional health care system follows a "sick-call" model of care, designed to address prisoners' acute care needs during specified hours. To further complicate matters, HIV care sites may be located far from jails, making it logistically difficult to transport prisoners to care. Also, prisoners may fear discriminatory treatment or loss of confidentiality.

Inmates with longer sentences generally are sent to prison where the barriers to entry into care are similar to those seen in jails (e.g., disclosure issues, understaffing, lack of HIV screening). There

are additional logistical issues to address in prisons because inmates are often moved from prison to prison, which necessitates them having to reestablish relationships with nurses, providers, and a new prison system.

White stated that there are approximately 70 prisons in North Carolina, and prisoners are moved an average of four times during their sentence. Most counties in North Carolina have a jail, which is under the jurisdiction of the county sheriff whose primary duties do not include health care. To overcome barriers in the correctional system, the state has put in place a system to identify HIV-positive individuals at entry, facilitate entry into care during incarceration, and promote follow up for HIV care post release. To accomplish these goals, the state correctional system has instituted a medical/social intake process that includes routine HIV testing and has employed 11 nurse case managers to engage inmates in care.

Some facilitators of continuity of care in prisons include:

- availability of specialized staff, such as HIV nurse case managers, HIV specialists (e.g., academic, public health, private, correctional staff), and HIV pharmacists;
- policies in place for treatment according to guidelines;
- effective non-discrimination and confidentiality policies; and
- financial resources to ensure access to ART.

Continuity of care following release can be compromised because often the application processes for Supplemental Security Income (SSI), Medicaid and/or ADAP may not be started until close to the time of release. White described how notification of benefit determination may occur after release, making it difficult to link clients to medical care. In many instances, there is limited access to inmates by community-based organizations that could assist with discharge planning and linkages to care. The consequences of discontinuity of care are evident from a study in North Carolina of 15 individuals who left jail, but were later incarcerated. Most of the recidivists had markedly increased viral loads at readmission to jail (Stephenson et al., 2005).

When HIV-infected individuals are released from prison, there is generally no easily accessible system of care for them. Consequently, these individuals often rely on emergency departments for care. White stated that an important means of facilitating continuity of care at release from jail or prison is collaboration between the community and correctional facilities. The case managers hired by the North Carolina corrections department also provide discharge planning upon release (with 30 days of ART) and address issues related to homelessness, mental health, and substance abuse. There is considerable variability in continuity of antiretroviral therapy and HIV care following release from prison or jail (i.e., care within 30 days of release) according to the research literature. Recent studies of persons with HIV released from Texas prisons found major interruptions in treatment following release, with only 30 percent of prisoners filling a prescription for ART within 60 days (Haillargeon et al., 2009) and only 28 percent enrolling in an HIV clinic within 90 days (Haillargeon et al., 2010). The SPNS Project Bridge program provided 18 months of intensive case management to ex-offenders in Rhode Island. More than 90 percent of prisoners in the program received medical care within 6 months of release from prison (Zaller et al., 2008). In another study, 65.1 percent of ex-offenders with HIV who received intensive case management after release attended a routine medical appointment within 4 weeks of release, compared with 54.4 percent of ex-offenders who had standard of care prison-administered discharge planning (Wohl et al., 2010). These projects demonstrate that successful collaborations can be forged between correctional and community-based care services.

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